U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 26 August 2005

CASE NO.: 2004-LHC-2776

OWCP NO.: 08-119532

IN THE MATTER OF:

JOSE TORRES,
Claimaint,

v.

BOLLINGER SHIPYARDS, INC.,
Employer,

and

AMERICAN LONGSHORE MUTUAL ASSOCIATION, LTD.,
Carrier

APPEARANCES:

Marvin Rader, Esq.,
On behalf of Claimant

Kevin Marks, Esq.,
Scott Greenwald, Esq.,
On behalf of Employer/Carrier

Before: Clement J. Kennington
Administrative Law Judge

DECISION AND ORDER AWARDING MEDICAL BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901 *et. seq.* (2000) brought by Jose Torres

(Claimant) against Bollinger Shipyards, Inc., (Employer) and American Longshore Mutual Assn., Ltd. (Carrier). The issues raised by the parties could not be resolved administratively, and the matter was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held before the undersigned on May 10, 2005, in Houston, Texas.

At the hearing both parties were afforded the opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs in support of their positions.[1] Claimant testified, called Travers "T.J." Hooks, Mario Garcia, Barry Steding and Santiago Torres, and introduced 44 exhibits, which were admitted, including: his personnel records including drug screen results and termination notice; choice of physician forms; medical records and depositions of Drs. Bonnen, Garcia and Madisetti; medical records from Drs. Pazkaban and Rodriguez; depositions of Mr. Scheffler, Mr. Knight and Mr. Palmintier; functional capacity evaluation; wage summary; as well as various Department of Labor filings. Employer called Larry Stokes, Max Sparre and Charlie Knight, and introduced 24 exhibits, which were admitted, including: various Department of Labor filings; Claimant's personnel file and wage records; medical records and depositions of Drs. Bonnen, Garcia, Madisetti and Rodriguez; medical records of Drs. Pazkaban, Mileski, and UTMB; depositions of Claimant, Mr. Scheffler and Mr. Palmintier; vocational records of Mr. Stokes and labor market survey.

Post-hearing briefs were filed by the parties.[2] Based upon the stipulations of the parties, the evidence introduced my observation of the witness demeanor and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. An accident occurred on March 19, 2001;

2. Claimant's injury was in the course and scope of his employment;

3. An employer-employee relationship existed at the time of Claimant's accident;

4. Employer was advised of the accident on March 19, 2001;

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[1] References to the transcript and exhibits are as follows: Trial transcript- Tr.__; Claimant's exhibits- CX __, p.__; Employer exhibits- EX __, p.__.

[2] Claimant submitted a 14-page, double spaced brief on July 8, 2005. Employer submitted a 15-page, double spaced brief on July 11, 2005.

5. Employer filed Notices of Controversion on 6/26/2001;

6. An informal conference was held on 3/19/2004; and

7. Employer paid Claimant disability benefits at a rate of $698.40 per week.

II. ISSUES

The following unresolved issues were presented by the parties:

1. The nature and extent of Claimant's disability;

2. Choice of physician;

3. Average weekly wage;

4. Employer's liability for unpaid medical bills; and

5. Attorney's fees.

III. STATEMENT OF THE CASE

A. Chronology:

Claimant is currently 43 years old. He fell twenty-three feet off of a ladder while working securing a chain fall on a barge March 19, 2001. He was treated at University of Texas Medical Branch (UTMB) by Dr. Mileski, who performed a physical examination, took spinal X-rays and MRIs, and diagnosed Claimant with mild disc bulges at C3-4, C5-6, C6-7, as well as moderate stenosis at C5-6 and disc herniation at T8-9. Claimant was treated with medication and released to work light duty on April 2, 2001, including no crawling, climbing, and maximum lifting of 40 pounds. Claimant was then referred to neurosurgeon Dr. Bonnen, who removed Claimant from work in April 2001, and treated his condition with physical therapy and non-steroidal anti-inflammatory medication. In May, 2001, Claimant was evaluated by neurosurgeon Dr. Pazkaban upon referral by Dr. Mileski. Dr. Pazkaban diagnosed Claimant with C6 radiculopathy and C5-6, C6-7 herniations. Claimant informed him he was taking Flexeril, Vicodin and ibuprofen, and Dr. Pazkaban recommended he continue his physical therapy.

A functional capacities examination performed July 25, 2001, released Claimant to medium duty work with lifting no more than 50 pound occasionally and 25 pounds frequently. Dr. Bonnen released Claimant to three weeks of light duty work on August 3, 2001, with restrictions of no work at elevated heights and lifting no more than twenty pounds. Claimant did return to his foreman position at Employer at this time. As he continued to complain of pain in September, 2001, Dr. Bonnen referred Claimant to Dr. Garcia for pain management and epidural steroid injections. Dr. Bonnen released Claimant from his care in November, 2001, stating he was not a surgical candidate and did not need a neurosurgeon's care. Dr. Garcia evaluated Claimant on only one occasion in October, 2001, and recommended the injections, which Claimant declined.

On March 22, 2002, Claimant was evaluated by Employer's orthopedic surgeon, Dr. Rodriguez, who diagnosed him with a soft-tissue injury and placed him at maximum medical improvement. Dr. Rodriguez recommended treatment with narcotic medications and exercise to improve Claimant's functioning and opined he could work with a lifting restriction of 50 pounds. In August, 2002, Claimant started treating with Dr. Madisetti, a pain management specialist. Dr. Madisetti noted Claimant's cervical disc bulges and thoracic disc herniation, but recommended against surgery. He treated Claimant with Vicodin, Soma and Xanax. Claimant exhibited good pain relief through June 2003, though he showed signs of anxiety in October, 2003. He treated with Dr. Madisetti on a monthly basis until May 2004 when he felt at maximum activity under his current medication and was referred back to his primary physician.

Claimant worked until April 5, 2004 when he took a leave of absence. He was formally terminated October 5, 2004, after six months of not working. In March, 2005, Dr. Rodriguez again evaluated Claimant, diagnosing him with chronic pain syndrome and recommending psychiatric evaluation before any return to work. However, he did note Claimant was physically capable of working within the restrictions of the 2001 FCE.

B. Claimant's Testimony

Claimant worked as a supervisor at Employer for 16 years, including the day of his accident. Claimant worked for both Halter Marine and Friede Goldman before Employer acquired the company on August 9, 2000. Claimant testified he performed the same job for all three companies; the actual owner was the only thing that changed. (Tr. 72-73). Claimant started out as a fitter welder responsible for fitting and welding pipe and plate onto various sea-going vessels. He testified some of the vessels were small, and some were large with multiple levels. He is a certified welder in pipe, plate, aluminum and stainless. Claimant testified he has not been re-certified in six or seven years because as a foreman it was not necessary. A few years after he started, Claimant was promoted to leadman and then foreman, which position he has held for 13 years. (Tr. 75, 116-17). Prior to his job at Employer, Claimant worked as a welder for HB

Zachary, U.S. Contractors, PPC and Blairworth; he described working in the refineries as lighter duty work than in the shipyards. (Tr. 110-11).

On March 19, 2001, Claimant fell while working on a two- or three-level barge. (Tr. 71, 75). The day before his accident, Claimant had worked on the barge to hoist the compressor out of the hold and onto the main deck with chain falls (hoists to lift heavy objects). On March 19, Claimant returned to the barge with new chain falls and noticed there was no fall protection in the box and nothing barricading the area. While Claimant was attempting to replace the chain fall, his ladder slipped and he fell sideways and down a 23-foot hole which was no bigger than four feet by six feet in circumference. Claimant testified the safety man measured 20 feet between the opening of the hole and the deck below, and Claimant estimated he was three feet up on the ladder. He had not been wearing fall protection at the time of the accident. (Tr. 75-76, 79, 133). Claimant landed on his heels and fell backward onto his buttocks before hitting his head, elbows and fingers. He was conscious after the fall, but was numb from the base of his neck to his waist; Claimant then clarified he was in pain all over and could not move; he remained still until the paramedics arrived and helped him off the barge. (Tr. 77, 79).

Claimant was in the hospital for two or three days; they took x-rays but did not give him medication or perform surgery. Upon his discharge he was prescribed pain killers, muscle relaxers and Xanax, and asked to follow up. The hospital was approximately fifteen miles from his home. (Tr. 81-83). After being discharged, Claimant's pain remained constant and severe; it only got worse over time and has never receded. (Tr. 83). The only surgery Claimant has had related to this accident was on his finger in 2002; no doctor recommended back surgery. However, on cross-examination, Claimant testified he did not tell his doctors he thought his hand injury was related to his accident. (Tr. 82, 130, 135).

Dr. Bonnen was Claimant's neurosurgeon of choice through UTMB, but he discharged Claimant from his care on November 12, 2001, stating there was nothing more he could do for him. Claimant did not recall Dr. Bonnen stating he was at MMI or that he no longer needed neurosurgical treatment, but he did recall Dr. Bonnen releasing him to work. (Tr. 103-05, 146). Dr. Bonnen referred Claimant to Dr. Garcia, a pain management specialist who recommended therapy and steroid injections for Claimant's pain; since Claimant did not want the injections he testified Dr. Garcia recommended he seek independent treatment from Dr. Yahtsu. Claimant's request to treat with Dr. Yahtsu was denied by Employer/Carrier. Claimant also met with Dr. Rodriguez at Employer's request, but did not remember Dr. Rodriguez placing him at MMI or returning him to work. Claimant then treated with Dr. Madisetti, whom he pays out of his own pocket. Claimant has not been reimbursed for any medical or travel expenses he has incurred; however, on cross-examination, Claimant testified he has not submitted any of the charges from Dr. Madisetti to Employer, nor did he seek authorization from Employer to

treat with Dr. Madisetti. Claimant has seen only Dr. Madisetti in the past three years; his office is 45 miles from Claimant's home. (Tr. 107, 147, 151-52).

Claimant further stated Dr. Madisetti did not sign off on Claimant's short-term disability because he only took Medicare. (Tr. 141-42). Claimant also testified Dr. Madisetti never signed off on any work release because he could not do that. Dr. Madisetti prescribed him Norco, a pain killer, Soma, Xanax, Valium, and until recently, Methadone. (Tr. 143-44, 152). Claimant testified the insurance company denied him from treating with Dr. Garcia a while back, though he indicated he could try to see him again. Only a few weeks before trial did Claimant become aware Carrier had approved his request to see Dr. Garcia. (Tr. 145).

Claimant testified he did not have any significant back problems prior to this accident and he did not previously take any medication for back pain or any type of joint pain. The only narcotic medication he ever took was that prescribed to him after his accident. (Tr. 78, 86). Prior his accident, Claimant had back spasms from lifting weight, for which he took medication; but, his condition did not last long and Claimant did not remain on the medication. On cross-examination, Claimant testified he pulled a muscle and strained his low back in 2000 for which he was prescribed narcotic medication. Claimant also testified on cross-examination that he was hospitalized for three days, and prescribed pain medication, following a car accident; he did not recall complaining of back and neck pain or being brought in on a back board in a cervical collar. (Tr. 87, 126-27).

On cross-examination, Claimant testified no physician has told him he has a drug problem. Claimant stated he does not have an alcohol problem, although he has had three DUIs and his medical records refer to chronic alcoholism in several spots. Claimant stated he has never been treated for alcoholism and has never attended Alcoholics Anonymous; however, Claimant then testified he is currently in A.A. as a condition for one of his DUI sentences. Additionally, Claimant testified he was diagnosed with Hepatitis C in 2000, which was caused in part by chronic alcoholism. (Tr. 124-26, 131). Claimant testified he has not felt any illness from his Hepatitis C and has only experienced anxiety and hot/cold sweats as a result of his over-active thyroid. He is currently on Methadone to wean him off of pain killers. (Tr. 132).

Claimant returned to work August 6, 2001, because he could not afford to live on just worker's compensation benefits. He went through a work ready program which he failed because of high blood pressure. When he finally returned to work, his supervisor, Max Sparre, informed him they did not have any light duty work for foremen; Claimant took this to be an ultimatum to either do his job or find other work. (Tr. 83-85). During the first year he worked after the accident, he was taking narcotic medication and complained to Employer's safety workers, his manager, Max Sparre, and superintendent Charlie Knight that he was in constant pain. His supervisors knew he was taking

narcotics and under the care of his doctor. (Tr. 85, 118). Following his return to work in August, 2001, Claimant had gall bladder surgery, was prescribed narcotic medication in his recovery, and was treated for high blood pressure. (Tr. 128-29).

Claimant testified he performed the same type of work as the general laborers underneath him; he described his position as that of leadman instead of foreman. However, he further testified the official description of his job submitted as CX-23, which included standing eight hours, walking eight hours, climbing, balancing, bending, stooping, kneeling, crouching, crawling, pushing, pulling, squatting and reaching above shoulder level 2.5-5 hours, accurately describes his job. He stated that he actually performed hard labor, including pulling wheels, tow shafts, and sometimes he cut the deck of a vessel to remove the main engine which involved the use of manual hoists. (Tr. 88-90).

When he returned to work, Claimant was required to perform basically the same job as before the accident; he testified his supervisors never told him not to perform heavy labor but pushed him as hard as before to finish jobs on time, but he did not recall instances where his supervisors complained about his performance. Claimant clarified he did not sit a desk or just stand on the dock directing his workers; he had to go onto the vessels and check that the work was done properly because he could not rely on anyone else to do it properly. He further testified the crawling, climbing and working on the tanks took a toll on his back, though he tried to perform his job duties to the best of his ability. (Tr. 88-91, 94-96, 99). Claimant testified he never attempted to modify his job duties post-accident; he always watched his men; he could not delegate to other men because he could not trust them. He stated he would not be able to perform his job with a lifting restriction of 25-50 pound and currently is unable to perform the job he had at Employer. (Tr. 96, 100-02).

On cross-examination, Claimant testified he had self-imposed lifting restrictions but when his men were not following orders he would have to intervene and get the job done, even if it included heavy lifting. Claimant stated even when maintaining these restrictions, he experienced increased chronic pain. His supervisors were okay with Claimant working within restricted lifting limits and never threatened he may lose his job. Indeed, Claimant testified his supervisors told him to work in a modified capacity and not do what he did before. (Tr. 137-38, 153). Claimant then testified he agreed with the other witnesses who all testified a foreman does not have to do physical labor, but can modify his job by delegating work to his crew members. (Tr. 139).

Claimant testified that at the time of his accident he earned $21.00 per hour and was scheduled to work five days per week, nine hours per day. He also earned three weeks of vacation time. Claimant testified he worked a lot of overtime. (Tr. 93-95).

Claimant has been in constant pain since his accident, for which he continues to take medication. The pain affects his sleep, and he has also developed an anxiety disorder. (Tr. 100-01). On April 5, 2004, he took a leave of absence and has not received any compensation from Employer or Carrier since that time; this decision was entirely his own and no doctor has told Claimant he needs to stop working. Claimant testified Employer paid him compensation for four or five months in 2001 and paid for his medical treatment from UTMB, Dr. Bonnen and Dr. Garcia. (Tr. 103, 135-36, 139).

On a daily basis, Claimant attempts to make something to eat and do some exercises; he does not engage in sports of any kind. He can walk but not for long before he gets tired and feels pain. (Tr. 114). On cross-examination, Claimant clarified he performs no housework and no yard work; he has not cut his lawn since his fall in March, 2001. Since April, 2004, Claimant has not looked for work and has not performed any welding duties. (Tr. 148).

Approximately three weeks prior to the hearing Claimant was hospitalized for a thyroid problem. (Tr. 109). Claimant has had three DWI convictions, the last one being a felony because it was his third. He presently does not have a driver's license and does not operate a motor vehicle. (Tr. 109-10). On cross-examination, Claimant testified that he did not reveal his third felony-DWI when questioned at his deposition. Claimant further reiterated he had no other felony convictions other than the DWI; however, he then testified he was convicted of felony assault in 1995 of 1996, as per his deposition testimony. Claimant was also arrested and convicted of deadly misconduct for firing a gun in 2000. (Tr. 120-23).

Claimant testified he can only stand for approximately 30 minutes, and he can sit for hours before having to get up; when he sits too long he feels pain from his toes to his neck. He has observed grocery store cashiers and does not believe he is capable of performing that job. Claimant does not know how to operate a computer and only has a ninth-grade education. He testified he did not finish high school, but then stated he received a high school diploma through a work program. (Tr. 111-13, 115). Claimant testified he can operate a forklift and a cherry-picker; he could perform these duties at work if he was allowed to stand up and move around every few hours. Claimant then testified he spends most of the day lying down because of his pain. (Tr. 112-13).

C. Testimony of Fact Witnesses

Travers "T.J." Hooks

Mr. Hooks was an electrician at Employer and worked with Claimant at the time of his accident. Mr. Hooks was with Claimant immediately before and after his fall, but he did not actually witness the fall. Mr. Hooks testified he heard a thump and saw crew members running down the steps, which alerted him that something bad had happened.

He then came upon Claimant lying on the ground; Claimant was not moving. He ran to the top of the deck to summon the barge's manager and call an ambulance, and by the time he returned Claimant was responsive and talking, though he did not move until the ambulance arrived. Mr. Hooks testified Claimant walked off the barge with some help; he clarified Claimant was not taken off on a stretcher, nor did he walk on his own. (Tr. 29-31, 36).

As an electrician for Employer, Mr. Hooks had the opportunity to observe Claimant's work as a foreman and stated Claimant ran the crew. He clarified that some foremen do physical labor, but it generally depends on what is going on and how much time constraint they are under. (Tr. 31-32). Mr. Hooks testified that as foreman, Claimant would do a lot of physical labor and "get down and get dirty." Because they worked on ships and barges, the work involved maneuvering small spaces and frequent bending, stooping, crawling, etc. (Tr. 32). On cross-examination, however, Mr. Hooks clarified that foremen have a lot of flexibility in the level of physical activity they perform; as such, Claimant had the ability to reduce his physical activities while still being able to keep his job. Specifically, Claimant could perform his foreman duties without doing any heavy lifting, but could delegate physical activities to other crew members. (Tr. 38).

Mr. Hooks testified he never heard Claimant's supervisors talk about him, either negatively or positively; he generally did not work under the same supervisors as Claimant. (Tr. 33-34). Mr. Hook testified he observed Claimant's work following his accident on March 19, 2001. Claimant continued to perform foreman work, though Mr. Hooks noticed a reduction in his level of physical activity. Mr. Hooks worked with Claimant ten years, and knew him to be a go-getter. He noticed Claimant slowing down following the accident, stating Claimant "definitely got slower, not as going as he used to be." (Tr. 34-35). Mr. Hooks also testified that in observing Claimant's appearance, he could tell Claimant was medicated on some days because he was slower and his speech was slurred. (Tr. 35).

On cross-examination, Mr. Hooks testified he is friends with Claimant and would want him to get whatever he is entitled to. He stated he was not aware of Claimant's back condition prior to the accident, nor was he familiar with the opinions of Claimant's physicians following the accident. (Tr. 36, 38).

Barry Steding

Mr. Steding is an electrician who worked with Claimant at Employer for eight years. He was not present for Claimant's March 19, 2001 accident, however, stating he was probably at the shipyard when the accident occurred. He testified he did not observe Claimant on the day of his accident. (Tr. 40). Mr. Steding testified he saw Claimant on a regular basis, every day, following his return to work after his accident. Prior to the

accident, he observed Claimant perform full duty work, including lifting, pulling, climbing stairs, pulling wrenches, and crawling in and out of small areas. After the accident, however, Claimant was "definitely different"; Mr. Steding testified Claimant could no longer take on the job as he once did, and complained about the pain he was in. (Tr. 41-42).

On cross-examination, Mr. Steding testified he is friends with Claimant. He also stated that the foreman's physical duties are flexible; each foreman can control how much heavy work he does. Even though Claimant did less physical work after his accident, Mr. Steding testified he was able to fulfill his duties as foreman. Mr. Steding also testified that Claimant worked for a long period of time following his accident, despite his complaints of pain. He never saw anyone treat Claimant negatively because of his injury. (Tr. 43-45).

Mario Garcia

Mr. Garcia was employed as a fitter welder under Claimant's supervision. On March 19, 2001, Mr. Garcia was at a different job site and thus did not witness Claimant's accident. Mr. Garcia testified he worked with Claimant for three and one-half years and knew him well. He described the work they performed as strenuous and involved hanging steel and putting shafts on boats. The men in their crew lifted items in excess of 100 pounds on a frequent basis. Mr. Garcia further testified the foremen have to get in and "lead the way," and need to assist new members of the crew to demonstrate what must be done. (Tr. 47-49).

Prior to the accident, Mr. Garcia did not observe Claimant take off work because of back pain; he was a hands-on foreman. After the accident, however, Claimant appeared to be in pain most of the time. Specifically, Mr. Garcia stated Claimant had difficulty going up and down stairs and climbing into the tanks. He testified the foreman can sit back on the dock and direct their crew without climbing into the tanks, but that was not commonplace. (Tr. 49-51). On cross-examination, Mr. Garcia clarified different foremen can handle the job differently; not all of them are hands-on foremen. He never heard anyone at Employer complain about the quality of Claimant's work. (Tr. 55-56).

Mr. Garcia further testified Claimant is his uncle, and he lived with him for four and one-half years; as such, he was able to observe Claimant's demeanor at work and at home. He testified Claimant's body deteriorated over time and he was not able to do the same things; Claimant has not worked since April 5, 2004. (Tr. 51-52). Specifically, Mr. Garcia testified Claimant complained about back pain while watching television, had difficulty sleeping. At work, Claimant continued to climb up and down stairs to access the vessels and would occasionally climb through holes to check for leaks. Additionally, Claimant was required to accompany the Coast Guard inspectors to inspect the welds; however, Mr. Garcia testified he substituted for his uncle. (Tr. 58-60).

Mr. Garcia no longer works at Employer, secondary to his felony conviction for possession of an illegal narcotic, Xanax. As Claimant's nephew, Mr. Garcia testified he loved his uncle and wants to help him. He testified Claimant does not have an alcohol problem and he never saw Claimant use drugs. (Tr. 53-54). Mr. Garcia has not lived with his uncle in a few years, but testified that Claimant no longer drives; his wife has driven him around for the past two or three years. Additionally, Claimant no longer keeps up with the maintenance of his house, but his family will help him out. Claimant can only cut the grass with a riding lawn mower; he can bend over, but Mr. Garcia testified Claimant cannot lift anything. Mr. Garcia testified he is not aware of Claimant's precise medical condition, nor his doctor's restrictions on physical activity. (Tr. 56-57).

Santiago Torres

Mr. Torres is Claimant's brother who was working with him on the day of his accident. Mr. Torres testified he witnessed the accident, which happened when Claimant slipped and fell while standing on a six-foot ladder hanging a chain fall. He witnessed Claimant fall twenty feet into a hole and onto a steel floor, landing on his back and rear. Mr. Torres immediately went to Claimant, who told him he could not move secondary to his back pain. Claimant did not start to move until the ambulance arrived at the scene. (Tr. 61-63).

Mr. Torres was able to observe Claimant's behavior as his brother and as a member of Claimant's crew. He testified Claimant was strong and never took off of work for back pain prior to the accident. Following the accident, Mr. Torres no longer worked with Claimant, but at home he did not see Claimant work around the house, or perform lawn work or auto repair; family members helped him out with these things. Claimant appeared to always be in pain, and he did not engage in any recreational activities. (Tr. 63-65). Claimant talked with Mr. Torres about his pain, and he never talked about getting better; Mr. Torres testified Claimant seemed to be in a lot of pain and in bad physical condition. (Tr. 66-67).

Mr. Torres was a general laborer at Employer and he testified the foreman's activities were the same as his; Claimant performed laborer tasks prior to his injury. On cross-examination, Mr. Torres clarified that he did not see foremen who did not perform physical activity; Employer expected everyone to perform physical work and foremen did not have the flexibility to alter the physical demand of their job. (Tr. 66, 69). Although Mr. Torres heard people talk bad about his brother after his accident, they never commented on Claimant's job abilities or duties and did not seem to want to run him off from working at Employer. (Tr. 68).

On cross-examination, Mr. Torres testified he loves Claimant and wants to see him get what is fair. Six years ago, Mr. Torres was convicted of attempted capital murder and

is just recently out of jail. Mr. Torres has also been convicted of felony forgery, a crime of dishonesty. (Tr. 70-71).

D. Employer's Witnesses

Max Sparre

Mr. Sparre has been the general manager at Employer's shipyard for 20 or 25 years, including the times when it was owned by predecessor companies. He has been at the shipyard a total of 40 years or more. As general manager, Mr. Sparre is responsible for everything at the shipyard. He testified he has known Claimant for the past 16 years and interacted with him on a daily basis up until Claimant left his job. However, on cross-examination, he testified he did not personally interact with Claimant daily, but that Mr. Knight did. (Tr. 168-69, 178). Mr. Sparre testified Claimant was an excellent worker, expressing no complaints about Claimant's job performance. (Tr. 169).

Mr. Sparre testified he was familiar with Claimant's accident of March 19, 2001; he understood Claimant was using chain fulls to pull out a machinery room of a barge. He did not witness the accident. Mr. Sparre stated Claimant was out of work six months following the accident and returned with light duty restrictions. He informed Claimant that "a foreman's job is about as light duty as you can get because you can point and instruct. You don't have to get in like he said the ditch and you know, and lift and pull or nothing. You instruct other people to do it." (Tr. 169-70). Mr. Sparre testified he was not aware Claimant's doctor released him to medium duty work; he only knew Claimant had a lifting restriction. (Tr. 170).

Mr. Sparre testified foremen at Employer's shipyard get a crew of 15 or 20 people working under him; he assigns each person to a specific task needed to complete the assigned job, and instructs them how to do it. On cross-examination, he added that the crew might be 10 or 5 people. Mr. Sparre described Claimant as a hands-on foreman, but testified that was not necessary or required of foremen. Claimant had the flexibility to be a hands-off foreman upon his return to work in August 2001. (Tr. 171, 177-78). Mr. Sparre clarified that Claimant's position as foreman did not require him to do heavy lifting. He observed Claimant performing some stooping, but when he admonished Claimant to delegate the task to a crew member, Claimant told him he could not rely on anyone. Mr. Sparre also testified there was more than one foreman assigned to a job. He clarified Employer would have accommodated Claimant so that he would not have had to lift, stoop, squat or crawl into the tanks. (Tr. 171-72). In general, it is common for foremen at Employer and throughout the industry to become less hands-on as they age. (Tr. 174). However, on cross-examination, Mr. Sparre testified foremen are required to do their job on the vessels themselves; even light duty foremen climb in and out of the ships. He added that only some, not all, of the work is in tanks. (Tr. 182-83).

Mr. Sparre, however, also testified he did not make any specific concessions to Claimant and did not discuss with Claimant his work duties based on his physical restrictions. He never encouraged Claimant to do less lifting, squatting or stooping, aside from advising him to delegate those jobs to his crew members. (Tr. 172-73). Mr. Sparre testified he never discussed with Claimant his inability to perform foreman duties; he just told him to do what he could do. The first few years he was back on the job following his accident, Mr. Sparre thought Claimant was doing very well. He testified that in the last year Claimant worked at Employer, Claimant's speech started to slur. However, Mr. Sparre testified Claimant continued to perform his job duties at a satisfactory level. (Tr. 173-74). On cross-examination, Mr. Sparre testified he did not know personally what Claimant told Mr. Knight about his pain, or what level his pain was at. Additionally, Mr. Sparre testified he never went to the jobs at Pier 41 in Galveston, where Claimant often worked and where his injury occurred. He primarily worked in the office and observed jobs in the yard, and would only see Claimant working when he was on the deck of a vessel. (Tr. 178-79, 184).

On cross-examination, Mr. Sparre testified Employer does not tolerate its employees taking prescription narcotic drugs. They perform random drug testing and Claimant has cleared said drug testing in the months and years after his accident. His prescription medication never showed up in Employer's drug tests, and they were not a factor in Claimant's termination. (Tr. 177, 183). He further testified he was not aware of Employer terminating six employees who filed worker's compensation claims. However, he stated Employer does not allow individuals on pain medication to work as they are at a heightened risk for falling; additionally, Employer cannot provide beds for injured workers to lie down on relieve their pain. (Tr. 180-82).

In the weeks leading up to his final day of work, Claimant started missing work secondary to back pain. One day, he went and told Mr. Sparre he could not do it anymore and needed to take time off. Mr. Sparre testified he advised Claimant to file for disability benefits. Prior to Claimant's last day, Mr. Sparre attempted to further accommodate Claimant and assigned him to giving welding tests and other yard work. There was no squatting, lifting or stooping involved in these jobs. (Tr. 174-75). Claimant was automatically terminated after six months of not working. Mr. Sparre testified he did not know of any medical evidence to support Claimant's leave from work. (Tr. 176).

Mr. Sparre reiterated he thought Claimant was a good worker, even in light duty capacity, and would re-hire him in a minute if Claimant was so willing and the decision cleared Corporate. (Tr. 176). He further stated no one talked to him about Claimant's potential for returning to Employer. Specifically, Mr. Sparre was not familiar with CX-2, a document directing that Claimant is not to be re-hired, because that was a Corporate issue. Mr. Sparre conceded if Corporate does not allow him to re-hire Claimant, he cannot do so. (Tr. 179-80). He also testified that Claimant was a foreman after his injury

only off and on, explaining that "you had to get on to Jose for stuff because that's the way he is." Mr. Sparre was of the opinion that Claimant did not really want to get in the trenches with his crew members. (Tr. 183-84).

Charles Knight

Mr. Knight has been with Employer and its predecessors for approximately 20 years. For the past ten to fifteen years he has been the yard supervisor in Texas City, Texas. He knows Claimant, as he is responsible for signing Claimant's daily tasks; on occasion he also gave Claimant his daily job assignments. Mr. Knight was Claimant's immediate supervisor. (Tr. 185-86). The only problem he had with Claimant prior to his March 19, 2001 accident, was that Claimant on occasion failed to show up for a 40-hour work week. This was a common problem prior to his accident. However, Mr. Knight testified Claimant was a very good worker. (Tr. 186).

Mr. Knight testified the foremen at Employer are in charge of a group of men and are able to dictate what he wants to do. He further stated he was unaware of any restriction placed on Claimant when he returned to work after his accident. Claimant appeared to take it easy for a little while, and then he got right back into his job. (Tr. 186-87). Mr. Knight also testified however, that the physical demand levels of a foreman depended on the job assignment; some jobs could involve heavy, medium and light duty work. However, he specified that as foreman, Claimant had the ability to direct his particular work in a light duty fashion. Following his injury, Claimant was not required to lift on the job, but did have to squat or crawl underneath the vessel or to get into a compartment at times. He could delegate 90% of his tasks, but not all of them. The frequency of having to squat or crawl was dependent on the job at hand; sometimes Claimant would have to do these activities a lot, other times not at all. (Tr. 187-89).

For the first couple of years Claimant returned to work after his job, Mr. Knight did not observe any difference in his performance. However, after that Claimant started experiencing more and more problems until he told Mr. Knight he could not do the job anymore. Mr. Knight testified Claimant lost enthusiasm for his job and started to experience slurred speech. He added that on numerous occasions he told Claimant not to perform the physical work he had been doing; he advised Claimant to take the job easier. To accommodate Claimant's pain, he assigned Claimant a smaller crew and allowed him to stay on the dock more and pick lighter tasks for himself. (Tr. 188-89, 196). Mr. Knight testified Claimant performed his modified job satisfactorily up until his last day. He was never presented with a medical release stating Claimant could no longer work. However, in the week prior to his last day of work, Claimant appeared to be in bad pain and was not able to do his job. (Tr. 190, 207).

Although Mr. Knight testified he never discussed Claimant's pain or limitations with him one-on-one, nothing was brought up at the safety meetings and he was never

provided with a written set of instructions, restrictions or limitations. When Claimant complained about his pain, Mr. Knight discussed it with the safety man. (Tr. 195). Mr. Knight further testified if Claimant's pain required him to lie down and rest frequently throughout the day, he would not be able to perform his job duties as a foreman. However, he clarified that employees are not discouraged from taking breaks when needed. (Tr. 197).

Mr. Knight testified the job description of Claimant's position, submitted as CX-22, was not completely accurate in that nobody is required to pick up 100 pounds. Additionally, the activities listed in the description are not consistently required of the workers; the job activities depend entirely on what the assignment is that day. However, he stated that each of the activities listed are involved in Claimant's position to some extent. (Tr. 191-92). He also testified that foremen cannot delegate 100% of their physical tasks because it is sometimes necessary to demonstrate the tasks to their crew members. However, Mr. Knight added that when Employer bought the company they instituted a new policy requiring foremen to delegate physical work to the crew members in an effort to reduce accidents; Mr. Knight testified he encouraged Claimant to follow this policy and let the crew members perform the physically demanding tasks. (Tr. 193-94).

With respect to CX-22, Mr. Knight specifically testified Claimant would stand and walk up to six hours; these activities were not performed constantly as foremen took breaks, ate lunch, wrote reports and did JSAs. The amount of climbing depended on the job, but it would not be more than 2-5.5 hours in one day. Mr. Knight testified it would be the same for bending and stooping. However, Claimant would not have to squat, grasp, reach above shoulder level or push/pull more than 5 hours per day. (Tr. 198-200, 203). Mr. Knight further stated if Claimant was working a job underneath a vessel, he would have to kneel for eight hours; he could not remember if Claimant worked a bottom job after his accident. He added that if Claimant could not perform the requisite kneeling, crouching and crawling for a good reason, there would be no repercussions. (Tr. 201-02). Upon Claimant's return, he was not required to lift more than 50 pounds. Further, if Claimant ever expressed an inability to perform these tasks secondary to his pain, he would not suffer any repercussions. (Tr. 204).

On re-cross examination, Mr. Knight identified one of Claimant's evaluation forms he filled out and signed in 2003. Mr. Knight testified he is a hard evaluator; he gave Claimant two "exceptionals," seven "averages," and two "poors." He explained that Claimant rated poorly in his reliability, attendance and punctuality. (Tr. 206-07).

Deposition of Will Scheffler

Mr. Scheffler is the branch manager for American Longshore Mutual Association's claims office at F.A. Richard and Associates; he supervised the claims

managers assigned to Claimant's claim, though neither individual is currently with FARA. Mr. Scheffler testified by deposition on May 6, 2005. (EX-22, pp. 1-6). As branch manager, Mr. Scheffler was responsible for reviewing claims on an as-needed basis, based upon the experience of the claims manager and severity of the case. He testified his boss, Ellen Goldring, reviewed Claimant's claim on June 12, 2001, November 12, 2001, December 2001, February 7, 2002 and June 20, 2002. The noted indicated Claimant returned to work light duty, was referred to Dr. Garcia for pain management, and Claimant's average weekly wage. (EX-22, pp. 6-14). Mr. Scheffler reviewed the claim on September 23, 2002, January 15, 2003, March 10, 2003 and January 6, 2005. The notes documented Claimant's return to work at a modified position and his leave of absence in 2004. (EX-22, pp. 15-20).

Mr. Scheffler testified that on November 16, 2001, Claimant requested a change of physician to Dr. Yahtsu, as Dr. Bonnen recommended surgery which he did not want to undergo. However, the examiner noted, and so informed Claimant, that Dr. Bonnen made no mention of recommending surgery. (EX-22, pp. 22-24). Based on the nature of Dr. Bonnen's discharge, FARA did not authorize a change in physician to Dr. Yahtsu. Mr. Scheffler understood Dr. Bonnen discharged Claimant because he was only interested in narcotic medication. He further testified he did not believe Claimant should have another physician because Dr. Bonnen discharged him because he did not need further medical care and was seeking narcotic medication. However, when questioned, Mr. Scheffler could not recall where he saw that note. (EX-22, pp. 29-31). Dr. Bonnen talked with the medical case manager[3] on October 16, 2001, stating that he would not prescribe further medication or physical therapy, as Claimant had not participated fully in physical therapy. Dr. Bonnen's office informed the medical case manager that Dr. Garcia would not provide the injections to Claimant, as he was receiving various medications from different pharmacies and doctors. However, Mr. Scheffler stated there were no rumors of Claimant being a drug addict. He clarified that during the relevant time Claimant was allowed to choose his own pharmacy; he was not directed to any specific pharmacy. (EX-22, pp. 34-36).

Following the alleged refusal by Dr. Garcia, FARA authorized treatment at the Orthopedic Institute on March 22, 2002, and the Texas Brain and Spine Center on April 10, 2002. (EX-22, p. 38). FARA also issued Claimant a check for mileage, in the amount of $405.72, in 2003, and authorized and paid for an MRI in 2004. Mr. Scheffler testified FARA had not received any requests for payments for Dr. Madisetti; Claimant's file contained no notes, records or correspondence from Dr. Madisetti's office and Mr.

[3] Mr. Scheffler testified the medical case managers were registered nurses employed at Concentra. They did not oversee the claimants' treatment or medication, but ensured that claimants received quality medical care and complied with same. There was no notation by any medical case manager that Claimant did not receive adequate medical treatment. (EX-22, pp. 42-44).

Scheffler stated he was not sure if FARA would have approved the payments if Claimant had requested them. (EX-22, pp. 39-40).

On April 16, 2004, Claimant informed the claims examiner he took a leave of absence from work, but was not currently disabled by a physician. Mr. Scheffler testified as Claimant was not rendered disabled by a physician, he was not entitled to, nor paid, indemnity benefits. He explained that FARA does not pay indemnity absent medical evidence to support it, even if a claimant stops work secondary to pain. Mr. Scheffler further testified FARA relied upon the medical reports from Dr. Bonnen and Dr. Rodriguez, Employer/Carrier's choice of orthopedist, in analyzing Claimant's claim for benefits. (EX-22, pp. 25-27). Mr. Scheffler testified he was not aware of any disagreement among Claimant's doctors about his condition and recommended treatment plans.

Deposition of Don Palmintier

Mr. Palmintier is the claims administrator for Bollinger Shipyard, Employer in the present matter; he testified by deposition on April 15, 2005. Mr. Palmintier's duty is to coordinate worker's compensation claims between Employer and the claims handler, FARA. He has 39 years of experience as a claims adjuster, and is familiar with the process of claims administration. (EX-23, pp. 1, 14-17). Mr. Palmintier testified he was not involved with the decision as to whether or not Claimant received any benefits. (EX-23, p. 20).

However, he testified Claimant was not paid benefits after April, 2004, because there was no medical evidence indicating he was unable to work, though he could not recall where he received this information. Mr. Palmintier testified Claimant was formally terminated after not working for six months; Employer's policy is to terminate employees who have seven unexcused days of absence. He further clarified that employees who miss work secondary to a work-related disability are required to call in once a week and update his supervisor on his condition. If they have seven unexcused absences, they are terminated but that is unrelated to any disability or worker's compensation claim they may have filed. (EX-23, pp. 25-27, 30, 38). Mr. Palimintier also stated the fact that a claimant may be terminated does not affect his disability status or impact the workers' compensation claim. He added that six employees with pending claims have been fired in the 18 months he has worked at Employer; he is currently actively working on less than one hundred open claims, but he did not know the exact number of worker's compensation claims currently pending. (EX-23, pp. 40-42).

Mr. Palmintier testified he did not review the medical records in this case, and did not have any conversations with anyone regarding drug abuse by Claimant. (EX-23, pp. 48-50).

E. Testimony of Larry Stokes

Mr. Stokes is a licensed rehabilitation counselor and professional mental health counselor in the State of Louisiana, and is board certified as a rehabilitation counselor, case manager and life care planner. (Tr. 208-09). Mr. Stokes has worked with Longshore claimants since he first entered the vocational rehabilitation field in 1982, testifying in various courts about 25 times per year. Mr. Stokes was accepted by the court as an expert witness in vocational rehabilitation. (Tr. 210-12).

Mr. Stokes evaluated Claimant on April 14, 2005. He was able to review Claimant's first deposition and various medical records from Drs. Shaw, Bonnen, Poleski, Wolf, Rodriguez, Pazkaban and Garcia; Texas Brain and Spine Center; UTMB; Orthopaedic Institute for Spinal Disorders; and the Pain and Rehabilitation Association of Texas, as well as Claimant's FCE. Since issuing his report, Mr. Stokes has reviewed Claimant's second deposition as well as the depositions of Dr. Garcia, Dr. Bonnen and Dr. Madisetti. (Tr. 213; EX-14, pp. 1-2).

At the April, 2005, evaluation, Claimant informed Mr. Stokes he did not possess a valid driver's license. Claimant also stated he needed assistance with daily activities, including bathing, tying his shoes and cooking. Though he groomed himself every morning, Claimant could not exercise. He mostly lied around the house and walked his dog. Mr. Stokes noted Claimant's description of his daily activities was not consistent with his medical records. (Tr. 214-15; EX-14, p. 2). Additionally, Claimant affirmatively told Mr. Stokes he did not have any felony convictions. Claimant also told Mr. Stokes he finished the eighth grade, but later received a high school diploma, and possessed a minimal ability to read, write and handle money. (Tr. 215-16). Mr. Stokes noted Claimant's work history included certifications in welding, forklift driving and safety coordination. Claimant's prior jobs included positions as a short order cook, dump truck driver, general construction laborer and welder. For the last 16 years he worked, Claimant was a welder fitter foreman. (Tr. 217-18; EX-14, pp. 2-3).

Claimant told Mr. Stokes he had been unemployed since he last worked at Employer in April, 2004. He took himself off of work secondary to back pain and has not returned. (Tr. 218). Pursuant to Claimant's medical records, Dr. Wolfe, the emergency room physician, released Claimant to light duty work on April 2, 2001, with maximum 40 pounds lifting, 20 pounds pushing/pulling, with no reaching away from the body, crawling or climbing. In September, 2001, Dr. Bonnen released Claimant to medium work with lifting up to 25-50 pounds; he maintained this opinion in his May 2005 deposition. (Tr. 220-21). Dr. Garcia testified Claimant would not be able to perform the duties in his job description without treatment, but Mr. Stokes noted Dr. Garcia never assigned work restrictions to Claimant. Further, Mr. Stokes testified the FCE performed July 25, 2001, released Claimant to medium duty work. Dr. Rodriguez

agreed with Dr. Bonnen's assessment and the FCE. Additionally, Dr. Madesitti never removed Claimant from work. (Tr. 221-23).

Mr. Stokes testified Claimant scored a 61, extremely low, on the Beta 3 intelligence test and a 62, low to mild deficit, on the Kaufman Functional Academic Skills test. On the Vocational Preference Inventory, Claimant did not score high in any of the six major occupational themes, indicating that returning to work was not a high priority for him at the moment. (Tr. 223-26; EX-14, pp. 5-6). On the Work Orientation and Value Survey, Claimant scored high in mission, conditions, time orientation, tasks and co-worker relations. On the Job Search Attitude Inventory, Claimant exhibited a likelihood of using networks to find a job instead of seeking one out independently. (Tr. 226-27; EX-14, p. 6).

Based on his evaluation and interview with Claimant, Mr. Stokes testified Claimant has worked in light to heavy duty jobs, ranging from unskilled to skilled. His transferable skills include working to precision, working with handles, machines, making, repairing, barring specifications and standards, training and supervising other people. Additionally, Mr. Stokes opined Claimant had an average general educational development, in keeping with his actual education and on-the-job experiences and training. (Tr. 227-28; EX-14, p. 7). Mr. Stokes testified this background would generally describe someone who his fairly motivated and self-directed; however, Claimant scored lower on lower on aptitude tests than Mr. Stokes expected him to given his work functional ability. He accounted for the discrepancy by explaining that some people are not educationally oriented or may have been nervous or uncomfortable during the test. He also noted Claimant forgot his reading glasses at home, which may have contributed to his lower score. However, his ultimate opinion was that Claimant can function at a higher level than indicated by his test scores. (Tr. 228-30; EX-14, pp. 7-8).

Mr. Stokes testified that based on the opinions of Dr. Bonnen and Dr. Rodriguez, Claimant was at MMI and able to return to work as a welder/supervisor in some jobs; this was consistent with the FCE, as well. Based on the fact Claimant had returned to work, Mr. Stokes opined he had no loss of earning capacity. (Tr. 232; EX-14, p. 9). He added that the highest goal of a vocational counselor is to return an individual to his prior job, either in full or modified capacity. Based on the testimony he heard at the hearing and Claimant's work and medical records, if taken as true, Mr. Stokes stated Claimant was able to perform his job successfully and did not need rehabilitation. (Tr. 233-34).

Looking at Claimant's past jobs, Mr. Stokes opined Claimant had the physical and vocational ability to return to work as a dump truck driver or short order cook. (Tr. 235-36). Mr. Stokes also identified alternative jobs available on the open market, pursuant to the wide variety of doctors' opinions restricting him to different levels of work. Specifically, his report included jobs in the sedentary, light and medium duty work categories. He testified his job chart included information on the physical demand level,

number of openings in Claimant's geographic area, the weekly wage ranges and average weekly wage for each type of position. (Tr 238-39; EX-14, pp. 8-9). Mr. Stokes performed a labor market survey, identifying three open positions in Claimant's geographic area of metropolitan Houston, Texas: cashier, pizza maker and child care worker with average earnings, between $259.60 to $280.00 per week. He sent the job descriptions and information to Claimant and all of his doctors for approval. Dr. Rodriguez replied that Claimant could not perform any of the jobs because he was depressed and needed psychological intervention. However, from an orthopedic standpoint, which is the doctor's specialty, he opined Claimant could perform all of the jobs listed. (Tr. 241-44; EX-14, pp. 9, 11).

On cross-examination, Mr. Stokes testified he was unaware Employer's corporate office had indicated they would not rehire Claimant. (Tr. 246). He also clarified that nobody completely restricted Claimant from performing any work; although, different doctors placed different levels of restrictions on him. (Tr. 248). Mr. Stokes acknowledged, however, that Dr. Garcia opined Claimant could not return to his job as welder/foreman, based on the job description provided to him by counsel which included lifting 100 pounds infrequently and 50 pounds frequently. However, Mr. Stokes testified he did not take Dr. Garcia's opinion to apply to Claimant's job as modified by Employer. (Tr. 250-51). Mr. Stokes further understood Mr. Knight's hearing testimony to mean that Claimant could not perform his job toward the end secondary to complaints of pain. (Tr. 253-54).

In his report, Mr. Stokes took into consideration the fact that Claimant's heart rate did not correlate with his complaints of pain at the FCE, and that his lifting capacity was limited by complaints of lumbar pain. He also noted that Claimant was of the opinion he could not perform any of the jobs identified secondary to his need to lie down during the day to relieve his pain. (Tr. 258-59). Mr. Stokes further testified that if the undersigned is to credit Claimant's complaints of pain, he would not be employable at this time. Specifically, Claimant would not be able to maintain gainful employment if he indeed needed to lie down throughout the day. (Tr. 260-61). He also stated he has never seen an individual return to work, even in a modified capacity, for over two years before stopping secondary to pain, unless something else had happened to affect his functional capacity. (Tr. 263).

F. Medical Evidence

(1) Dr. Mileski and UTMB Records

Claimant was taken to UTMB by emergency medical personnel on March 19, 2001, following his work accident. He complained of heel, elbow and low back pain as well as transient numbness. X-rays of his spine and pelves, as well as cervical and thoracic MRI scans, were all negative according to Dr. Mileski's notes. However, the

MRI report from the radiologist indicated mild bulging at C3-4, C5-6 and C6-7 with C5-6 mild to moderate stenosis secondary to osteophytes and bulging. The MRI also revealed a small central-left HNP at T8-9 with no spinal stenosis. (EX-15, pp. 7-9). Claimant was kept at UTMB overnight for observation, and was discharged on March 20, 2001, with prescriptions for ibuprofen, Flexeril and Vicodin and an instruction to not engage in heavy lifting or strenuous activity for four to six weeks. The medical records indicate Claimant was not cleared to return to work on March 20, 2001. (EX-15, pp. 5-7; EX-19, p. 137).

Claimant followed up with Dr. Mileski on March 28, 2001, with complaints of coccygeal pain. Dr. Mileski again noted no radiographic evidence of Claimant's injury. He authorized Claimant to return to light duty work on April 2, 2001, with no crawling, climbing ladders, maximum lifting of 40 pounds, maximum pushing and pulling of 20 pounds and no reaching away from his body. He discharged Claimant from his care, instructing him to follow up as necessary. (EX-15, pp. 1-4). On April 11, 2001, however, Claimant returned to UTMB with complaints of muscle tightness and soreness in his back. He was referred to neurosurgeon Dr. Bonnen. (EX-19, p. 15).

In the spring of 2002, Claimant treated with Dr. Shah at UTMB to correct a long-standing problem of bent right small finger. A partial palmar fasciectomy, right hand, right small finger was performed on April 1, 2002, to correct the problem. (EX-19, p. 72).

(2) Deposition and Medical Records of James Gregory Bonnen, M.D.

Dr. Bonnen testified by deposition on May 5, 2005, as an expert witness in neurosurgery. He has been a physician for thirteen years and was board-certified in neurosurgery 7 years ago. (EX-9, pp. 2-3). Dr. Bonnen first treated Claimant on April 19, 2001, at which time Claimant informed him he fell off of a ladder at work one month earlier, was treated at the hospital for a few days before being sent home; there was no note Claimant suffered preexisting neck or back problems.[4] Dr. Bonnen reviewed Claimant's cervical and thoracic spine MRIs taken on March 19, 2001, noting three bulging discs in Claimant's neck and one in his mid-thoracic spine; none of the bulges, however, compressed his spinal cord. (EX-9, pp. 3-4; EX-16, p. 4). Upon physical examination, Dr. Bonnen noted Claimant was neurologically intact; he described Claimant's complaints of pain as subjective in nature. Specifically, Dr. Bonnen noted Claimant's pain was predominantly in his thoracic spine, which he opined were not caused by his cervical bulges. However, Dr. Bonnen went on to state Claimant complained of pain throughout his spine, including his neck and lower back. Dr. Bonnen

[4] Dr. Bonnen testified he was not aware how Claimant came to see him. He stated he did not have any dealings with Employer or Carrier; he did not even know their identities until the deposition. (EX-9, p. 25).

diagnosed Claimant with degenerative cervical disc disease; he explained this condition can be a combination of wear and tear on the body with superimposed trauma over time. Dr. Bonnen testified he did not render an opinion as to whether Claimant's condition was related to his work accident, as his concern is caring for the patient. He went on to testify he could not say for certain if Claimant's accident was the sole cause of his symptoms. However, he also testified did not treat Claimant before his accident and did not have any MRI films prior to his accident, so he did not know if the disc bulges existed prior to the accident. (EX-9, pp. 4-5; EX-16, pp. 4-5).

Dr. Bonnen recommended physical therapy for Claimant and prescribed him non-steroidal anti-inflammatory medication. He stated Claimant was not a candidate for surgery, but opined he should be able to return to work in six weeks. Claimant informed him he was not allowed to work secondary to the pain medication he was taking. (EX-9, p. 5; EX-16, pp. 4-5). Dr. Bonnen testified that on April 25, 2001, Claimant expressed a desire to return to work; he released Claimant to work with restrictions as of May 1, 2001, and ordered a functional capacity evaluation (FCE). (EX-9, p. 6).

Claimant presented to Dr. Bonnen on May 17, 2001, with continued complaints of mid-thoracic pain as well as some numbness in his left upper extremity; Claimant informed Dr. Bonnen that Dr. Pazkaban told him he had left C6 radiculopathy and would need an EMG if his symptoms did not improve; he also offered Claimant an operation. Dr. Bonnen diagnosed Claimant with thoracic pain and possible left C6 radiculopathy; he released him to return to work essentially without restrictions. However, in a note to Claimant's insurance company dated May 17, 2001, Dr. Bonnen reported he did not release Claimant to full duty work nor any type of light duty work. Dr. Bonnen reviewed Dr. Pazkaban's records at his deposition, finding no indication he offered Claimant surgery. Dr. Pazkaban merely recommended further physical therapy and possible additional diagnostic studies. On cross-examination, Dr. Bonnen stated Claimant's numbness was an indication of potential nerve irritation. (EX-9, pp. 6, 24; EX-16, pp. 8-9, 29-30). On June 12, 2001 Claimant reported improvement with physical therapy and primarily complained of mid-thoracic pain. Dr. Bonnen diagnosed him with thoracic pain, cervical radiculopathy and degenerative cervical disc. (EX-16, p. 9).

As of July 18, 2001, Claimant's condition was improving and Dr. Bonnen intended to keep him on physical therapy for a few more weeks. He testified the only limitation to Claimant's physical demand levels was pain; he diagnosed Claimant with cervical radiculopathy and insomnia. (EX-9, p. 7; EX-16, pp. 10-11). The FCE ordered by Dr. Bonnen was conducted July 25, 2001. Claimant complained of a stiff back and back pain which was worse with bending and lifting. Claimant's pain was a one out of ten prior to the testing, and an eight out of ten after the testing. The FCE noted Claimant's job duties included crawling and heavy lifting. The FCE concluded that Claimant could function within the medium physical demand level; lifting 50 pounds infrequently, lifting 25 pounds and less frequently, with possible difficulty working in confined spaces. It also

recommended Claimant complete his physical therapy as prescribed, (EX-13; EX-16, p. 7).

Dr. Bonnen did not recall placing any physical restrictions on Claimant, although he stated that on August 3, 2001, he released Claimant to work light duty for three weeks restricting him from working at elevated heights and lifting more than 20 pounds. On September 26, 2001, Claimant did not feel he could perform his work duties; he complained of pain running from his neck to his lower back. As such, Dr. Bonnen referred him to a pain management specialist for further treatment and consideration of epidural steroid injections. However, Dr. Bonnen released Claimant to work. (EX-9, p. 15; EX-16, pp. 38, 46).

Dr. Bonnen testified Claimant was at MMI in September 2001 and he did not anticipate that Claimant's condition would worsen in the future, as a result of the injury; however, his notes indicated Claimant was not yet at MMI. (EX-9, p. 8; EX-16, p. 12). Dr. Bonnen reviewed the report of orthopedist Dr. Rodriguez, who opined Claimant was at MMI with respect to orthopedic treatment; on April 10, 2002, Dr. Bonnen concurred with Dr. Rodriguez's opinion that Claimant had reached MMI as related to all treatment, including his pain management. (EX-9, p. 9; EX-16, p. 12). Dr. Bonnen also signed off on Claimant's job description in April 2002, opining he could return to work with the restriction of not lifting more than 50 pounds; he testified this report reflects his opinion on Claimant's ability to work in September 2001, as well. (EX-9, p. 7; EX-16, pp. 12, 59).

Dr. Bonnen testified the Clinic Notes included in his medical records were generated by the nurses on his staff. The notes confirmed that he and his staff recommended physical therapy and pain management to include epidural steroid injections. The notes also indicate Claimant did not follow through with these treatments and frequently requested various types of medications. The August 23, 2001 clinic note reported Claimant did not complete his physical therapy as prescribed. (EX-9, p. 9; EX-16, pp. 1-3). Dr. Bonnen explained he does see patients who are primarily interested in getting prescriptions for drugs; based on the frequency of Claimant's requests for specific quantities of specific drugs, as well as Dr. Bonnen's training and experience with drug-seekers, he was concerned Claimant may be drug seeking. However, he also testified pain is subjective and he tries not to get involved in pain management or assess a patient's psychological motivations. Dr. Bonnen further testified that Claimant revealed he was receiving narcotic medication from more than one doctor and was taking more than the prescribed dosage for his condition. He stated it is his policy to not prescribe narcotics to a patient who is receiving them from another physician at the same time. (EX-9, pp. 10-11; EX-16, pp. 1-3).

On November 8, 2001, Dr. Bonnen released Claimant from his care he testified there was nothing he had left to offer Claimant and referred him to a pain management

specialist. Dr. Bonnen opined Claimant no longer needed the care of a neurosurgeon, he did not feel it necessary to refer Claimant to an orthopedic specialist. Moreover, Dr. Bonnen felt Claimant was capable of working within the above restrictions even if he chose not to go to pain management. (EX-9, p. 8). Additionally, Dr. Bonnen testified he had no interest in being his pain management physician, though he stated he would continue to see Claimant if he thought he could help him. Dr. Bonnen added that he generally does not prefer to be anyone's treating physician, though he will consult on worker's compensation cases. Notwithstanding, his records include a note in which Claimant specifically chose Dr. Bonnen as his choice of neurosurgeon on April 11, 2001. (EX-9, pp. 11, 27; EX-16, pp. 15, 48). Dr. Bonnen further testified he has no medical explanation for why Claimant's condition suddenly worsened, though he expressed concern that Claimant had a problem with dependence on prescription medication. (EX-9, p. 12).

Dr. Bonnen testified he last saw Claimant on May 19, 2004. (EX-9, pp. 17-18; EX-16, p. 13). He noted Claimant had been under the care of a pain management specialist, and was taking Narco, Soma, Valium and Methadone. He complained of pain throughout his entire spine and radiating to the bottom of his feet; he described the pain as standing on needles. Dr. Bonnen stated Claimant cut himself off of work because he could no longer function secondary to his pain and the medication he was on. Claimant requested another MRI to determine the pathology of his pain; however, he did not perform one or review the reports. Dr. Bonnen referred him to pain management. (EX-9, p. 18; EX-16, pp. 13, 87; CX-24). Notwithstanding, his records included lumbar, thoracic and cervical spine MRI reports dated June 1, 2004, noting bilateral spondylolysis at L5-S1, moderate protrusion at T1-3, mild disk degeneration and bulge at T8-9, disc bulges from C3-7 with stenosis at C6-7 and stenosis and foraminal narrowing at C5-6. Dr. Bonnen noted these studies showed no significant change in Claimant's condition. Dr. Bonnen also refused to address Claimant's work or medication issues, though Claimant requested a note keeping him off of work. Dr. Bonnen testified Claimant appeared to have secondary gain on that last visit; however, he was unaware Claimant was not receiving any pay or pain medication. (EX-9, p. 18; EX-16, pp. 69, 78-80). On re-direct examination, Dr. Bonnen testified he never noticed any evidence of swelling, and Claimant's numbness had resolved in 2001. However, he stated that numbness can be the result of nerve impingement which may resolve and then re-appear down the road. (EX-9, pp. 27-28).

On cross-examination, Dr. Bonnen clarified he could not relate Claimant's current pain levels to his accident alone; it was not logical to him that Claimant's pain was under control in the fall of 2001 to where he was only taking ibuprofen but he then declined the point where he needed narcotic medication to get by. However, he did testify Claimant's pain could be the combination of the injury, any pre-existing conditions and/or repetitive injuries, which would be the reason doctors limit patient's physical activities. (EX-9, pp. 19-21; EX-16, p. 13). Dr. Bonnen stated Claimant did not have radicular symptoms

following his accident, but they developed over time necessitating physical therapy. Further, although the doctors at UT Health Sciences Center were capable of providing Claimant sufficient treatment, he did not think Claimant was in need of said treatment. (EX-9, pp. 21, 25).

(2) Medical Records of Peyman Pazkaban, M.D.

Dr. Pazkaban evaluated Claimant on May 4, 2001, upon referral from Dr. Maleski at UTMB. Claimant presented with neck and left upper extremity pain and numbness which started approximately two weeks after his March 19, 2001, work accident. Although the numbness in Claimant's arm had resolved, Dr. Pazkaban noted he still had numbness in his left fingers, significant neck pain and intermittent suboccipital headache. Claimant informed Dr. Pazkaban he was to start physical therapy and had been treated with Flexeril, Vicodin and ibuprofen. Claimant also stated he has not worked since his accident. (EX-17, p. 1). Upon physical examination, Dr. Pazkaban noted moderate left cervical paraspinal spasm and limited range of motion in Claimant's neck. He also reported diminished sensation over Claimant's left fingers. He reviewed Claimant's MRI films, which revealed disk herniations at C5-6 and C6-7; however, due to the low quality of the film he could not assess any foraminal narrowing. Dr. Pazkaban diagnosed Claimant with left C6 radiculopathy in the setting C5-6 and C6-7 herniations. He recommended physical therapy for four weeks and possible CT myelogram of cervical spine if his symptoms persist thereafter. (EX-17, p. 2).

(3) Deposition and Medical Records of Eduardo J. Garcia, M.D.

Dr. Garcia testified by deposition on March 31, 2005. He was accepted by the parties as an expert in the field of pain medicine. Dr. Garcia is board certified in anesthesiology, with a sub-specialty in pain medicine and also has separate certification by the American Board of Pain Medicine. (EX-10, pp. 1-3). Claimant was referred to Dr. Garcia by Dr. Bonnen for pain management and possible epidural steroid injections. Dr. Garcia testified he usually reviews a patient's medical records prior to his initial evaluation; however, he did not receive a copy of Dr. Bonnen's clinic notes. Had he seen those notes, which included various telephone calls by Claimant requesting specific drugs, he would have talked to Claimant in more detail about the medications he was currently taking and why. He stated the only information he had was what Claimant told him; Claimant did not mention he was taking Darvocet or receiving medications from Dr. Stafford and Dr. Lewis. Dr. Garcia testified he sees patients who are genuinely interested in improving their pain, as well as those who are seeking drugs because they are addicted or abusers of same. Specifically, he testified the number of calls Claimant made to Dr. Bonnen would have been a red flag that Claimant could have been abusing his medication, as was the note from November 2, 2001, indicating Claimant was receiving Xanax, Vicodin and Soma from Dr. Bonnen, Dr. Lewis and Dr. Stafford. However, Dr. Garcia clarified he would have discussed this further with Claimant to determine if he

was abusing his medication, or if he was just under-medicated. However, he further stated Claimant's overall behavior was not common for someone without a substance abuse problem. (EX-10, pp. 3-7, 22).

Dr. Garcia saw Claimant on October 31, 2001, at which time Claimant presented with complains of pain in his mid-back and in between his shoulder blades. Claimant informed Dr. Garcia of his March 19, 2001, accident consistent with his hearing testimony. Dr. Garcia noted Claimant had MRIs taken of his cervical and thoracic spine, which revealed bulging annulus at C5-6 causing mild to moderate stenosis and left-sided herniation at T8-9, for which he was treated conservatively. Claimant described his pain as 10 out of 10 at the worst, and 6 out of 10 at the best. Based on Claimant's MRI report, Dr. Garcia testified Claimant's injuries were consistent with his accident. (EX-10, p. 8; EX-18, p. 1). Additionally, the MRI tissue injury was very consistent with Claimant's trauma; Dr. Garcia testified he had never seen a thoracic disk injury that was not trauma-related. Upon physical examination, Dr. Garcia noted Claimant was overweight, exhibited discomfort upon ambulation but had good range of motion in his back. Dr. Garcia did not find any evidence of symptom magnification. He noted tenderness to pressure at Claimant's mid-line and lower cervical spine, indicating Claimant's injury was consistent with disc herniation and not muscular in nature. He also noted Claimant had asymmetric tricep reflex which was stronger in the right side than in the left, which was consistent with a C7 or C5-6 injury. (EX-10, pp. 9-10, 15; EX-18, p. 2). Overall, Dr. Garcia diagnosed Claimant with T8-9 disk herniation with moderately severe mid-back pain, secondary muscular spasticity, C5-6 spondylosis with stenosis, and improving C6 radicular symptoms. (EX-18, p. 2).

Dr. Garcia noted Claimant was not working at the time of his evaluation, because his employer would not allow him to work while he was on narcotic pain medication. Dr. Garcia did not assign Claimant any work restrictions, and testified he could not remember if he thought Claimant could work in October 2001. Dr. Garcia testified he would defer to Dr. Bonnen for any return to work opinion, as Claimant was not wholly transferred into Dr. Garcia's care, but only referred to him for pain management and injections. Additionally, Dr. Garcia did not know what Claimant's work activities or requirements were. However, he testified Dr. Bonnen's restrictions and Claimant's job description as presented to him in his deposition seemed reasonable in light of his symptomology. (EX-10, pp. 8, 10; EX-18, p. 2). Dr. Garcia further testified he did not think Claimant was capable of performing heavy duty work which included lifting more than 100 pounds infrequently, lifting 50 pounds frequently, crawling and climbing into awkward positions, and sometimes extending overhead or kneeling down and crawling, in the fall of 2001. He also testified if Claimant had not improved he would not currently be able to perform these duties. (EX-10, p. 23).

Dr. Garcia testified he recommended a thoracic epidural steroid injection (ESI) at the site of Claimant's disk herniation to get him past the plateau he had reached in his

pain level by just taking medication. (EX-10, p. 10; EX-18, p. 3). Dr. Garcia testified the ESI is not a controversial procedure, stating he has had good results in giving injections to other patients. Although the ESI would not cure the herniation, it would decrease Claimant's pain and allow him to function easier. On cross-examination, Dr. Garcia stated he felt Claimant needed the ESI; he would not recommend thoracic surgery which has a high morbidity rate and is too risky given Claimant's age and condition. (EX-10, pp. 16-17). If the ESI did not work to relieve Claimant's pain, Dr. Garcia would have recommended an exercise and traction plan with some opiate medications in the beginning for a finite period of time. (EX-10, p. 19).

Dr. Garcia, however, never saw Claimant after this initial evaluation and could not say why Claimant did not return. However, he testified he is willing to continue to treat Claimant and indicated it would take about six months to get Claimant functioning again. (EX-10, pp. 10, 23-24).

Dr. Garcia reviewed Dr. Madisetti's notes and testified he would not recommend the current treatment he was providing Claimant, as methadone, a cost-effective pain reliever, is a long-term opiate analgesic and likely to cause addiction. Additionally, Claimant showed little improvement under his current treatment method which included as many as four medications at one time. Given Claimant's age and condition, Dr. Garcia testified he would not give Claimant any of the medications he is currently prescribed rather, he would prescribe low-level non-steroidal anti-inflammatories with acetaminophen and possibly a muscle relaxer for any spacticity and an anti-depressant. (EX-10, pp. 11-13). Dr. Garcia clarified, however, that Claimant has exhibited signs of physical drug dependency in that he needs medication to function, but he is not necessarily addicted to drugs, which is a psychological condition. He testified it is possible to have a physical dependency without psychological addiction. To determine any level of drug addiction, Dr. Garcia recommended Claimant undergo a psychological evaluation. (EX-10, pp. 13, 17-18, 21).

Dr. Garcia further testified Claimant could not stop his current medications cold turkey without experiencing hyper-pain mode; he therefore suggested it would take about six months to wean Claimant off of his current medications. Dr. Garcia clarified the "hyper-pain mode" would be the result of Claimant's narcotic medication, and not his injury. If done properly, he opined Claimant would be able to continue to work while being weaned off of the medication. (EX-10, p. 14).

(4) Deposition and Medical Records of Narayan S. Madisetti, M.D.

Dr. Madisetti testified by deposition on March 31, 2005. He is board-certified in anesthesiology and pain management, and is licensed to practice in Louisiana, Texas and New York. The parties accepted him as an expert witness in the fields of anesthesiology and pain management. (EX-11, pp. 2-3).

Claimant first presented to Dr. Madisetti on August 2, 2002, with complaints of neck and upper back pain which was severe and constant in nature, and was aggravated by sitting. Claimant had been worked up by Dr. Bonnen and UTMB in the past, and was currently taking hydrocodone for his pain. He treated with Dr. Madisetti for pain management and symptomatic treatment. Dr. Madisetti reviewed Claimant's MRI and x-ray reports which revealed bulging disks from C3 to C7 and a narrowing of the spinal canal at C5-6. He also noted thoracic bulging disk with herniation at T8-9. He did not agree with Dr. Mileski that these tests were normal; however, he did not think Claimant needed surgery. (EX-11, pp. 4-5).

Dr. Madisetti did not have an opportunity to review Dr. Bonnen's medical records or notes on Claimant; he only went by what Claimant told him, which was not much. Dr. Madisetti was not aware Dr. Bonnen's office was concerned Claimant may have had a prescription drug abuse problem. Significantly, he was also unaware Claimant had been receiving various medications from different doctors and having them filled at different pharmacies, per Dr. Bonnen's clinic notes. He testified this behavior indicated to him Claimant may have been doctor shopping; Dr. Madisetti does not tolerate this from his patients and would have refused to treat Claimant had he known he was receiving medication from multiple doctors. (EX-11, pp. 6-8). Dr. Madisetti further testified the frequency of Claimant's calls to Dr. Bonnen and requests for medication indicated he was likely not receiving the right medication for his pain. He opined Claimant was not addicted to narcotic medications, as he never requested stronger meds, such as oxycontin, just more of the same medications. Overall, Dr. Madisetti testified Claimant did not exhibit signs of being a drug abuser, though he could not be positive. (EX-11, pp. 7-9, 11).

Upon physical examination, Dr. Madisetti noted Claimant had numbness and diminished sensation over his left index finger, an objective symptom consistent with C6 distribution. Claimant's toe and heel walk, as well as his straight leg raise tests were all negative; he complained of stiffness, but had no spasms. Dr. Madisetti testified Claimant's complaints of pain correlated with his C5-6 herniation. He prescribed Claimant Vicodin, Soma and Xanax, which were schedule C hydrocodone preparations and were habit-forming.. (EX-11, p. 10). Dr. Madisetti reiterated he prescribed these medications to Claimant because he was of the opinion Claimant was undermedicated. As of June 2003, Claimant reported satisfactory pain relief and was continuing to work, though in October 2003 Claimant exhibited signs of anxiety. Dr. Madisetti testified anxiety was a common disorder in people who suffer chronic pain. (EX-11, pp. 11-12).

Claimant treated with Dr. Madisetti on a monthly basis. Dr. Madisetti kept Claimant on drug therapy, noting Claimant was working and exercising daily. Dr. Madisetti testified that because Claimant's medications kept him functioning, he never restricted Claimant's work. He later testified he could not opine as to Claimant's work

restrictions or level of functioning as he is not Claimant's treating physician, but is only Claimant's pain management specialist. At his March 17, 2004 appointment, Claimant gave no indication he was having problems at work. Dr. Madisetti further noted Claimant was taking narcotic medication since he first treated him in August 2002, and was able to work until April 2004 with no problem. Claimant never informed Dr. Madisetti he could not work while on narcotic medication; Claimant would not be able to perform heavy duty work without pain unless he was taking medication. (EX-11, pp. 12-13, 18-19).

On May 13, 2004, Claimant reported pain from his back to his leg, and Dr. Madisetti prescribed Methadone, which was a stronger pain medication than he had been on. Although Methadone can be used to detoxify patients, Dr. Madisetti only prescribed a small amount for Claimant's pain. Claimant expressed he felt at maximum activity under his current medications, and Dr. Madisetti referred him to his primary care physician. (EX-11, pp. 13-14).

Dr. Madisetti testified Claimant is currently taking Methadone, Soma, Narco, Xanax and Valium; he stopped taking Zoloft. He stated he does not believe Claimant is getting medication from any other doctor, and gave Claimant the benefit of the doubt that he is not abusing his prescription drugs. (EX-11, pp. 14-15). Dr. Madisetti testified other options for treating Claimant's chronic pain include pharmacal therapy, relaxation, yoga, biofeedback and acupuncture; however, he testified pharmacal therapy is the most effective and best avenue for Claimant to pursue. (EX-11, pp. 16-17).

Dr. Madisetti testified he did not find Claimant to be a malingerer, but believed Claimant wanted to improve his pain and return to work. He testified Claimant is not going to improve without further therapy; currently, Claimant pays Dr. Madisetti $90 per visit out of his own pocket. (EX-11, pp. 18-19). Pursuant to Claimant's pharmacy records, he only has a $5 co-pay under his health insurance plan; his visits to Dr. Madisetti's office is 90 miles round trip, resulting in a total of 1,170 miles. (EX-12).

(5) Deposition and Medical Records of Jose E. Rodriguez, M.D.

Dr. Rodriguez is an orthopedic surgeon specializing in spinal disorders; he is board certified in orthopedic surgery and spinal surgery, and has been in private practice for the past 15 years. He testified as an expert witness by deposition on May 25, 2005. (EX-24, pp. 1-3).

Claimant was referred to Dr. Rodriguez by Employer/Carrier for an evaluation, which took place on March 22, 2002.[5] Claimant informed Dr. Rodriguez of his medical

[5] Although Dr. Rodriguez only evaluated Claimant on two occasions, because he personally examined Claimant he would not automatically defer to the opinions of a treating physician. (EX-24, p. 12).

history, including his March, 2001, work accident and subsequent treatment, in a consistent manner with his testimony at the hearing. Dr. Rodriguez reviewed X-rays of Claimant's cervical and thoracic spine taken at UTMB's emergency room in March, 2001, which revealed degenerative changes. Dr. Rodriguez noted Claimant's spinal MRI revealed disc bulges at C3-4, C5-6 and C6-7 with no herniation or nerve root compression; moderate spinal stenosis at C5-6; and left-sided herniated nucleus pulposus at T8-9 with no hematoma, spinal stenosis or cord compression. At his deposition, Dr. Rodriguez clarified disc herniation is one phase of disc degeneration; it does not happen to healthy, normal discs. In Claimant's case he could not tell if the thoracic herniation was a result of pre-existing degeneration or the result of his work accident. He further clarified the cervical disc bulges were consistent with degenerative disc disease, and not related to his work accident. On cross-examination, he testified trauma can expedite and contribute to the worsening of degenerative disc disease, which is what happened in Claimant's case. (EX-21, pp. 1-3; EX-24, pp. 3-4, 6, 19).

Dr. Rodriguez noted Claimant treated with Dr. Bonnen and returned to light duty work August 6, 2001. He was evaluated, but not treated, by Dr. Garcia and has not received medical treatment since October, 2001. (EX-21, pp. 1-2; EX-24, p. 3).

Claimant presented to Dr. Rodriguez with pain extending from the base of his neck into his thoracic spine, but no low back pain. He also reported some numbness in the lateral aspect of his thighs and in his upper extremities; Claimant denied headaches, blurred vision, slurred speech or passing out episodes. (EX-21, p. 2). Dr. Rodriguez testified an objective physical examination was largely normal, except for the numbness he found in Claimant's thighs; he explained this was secondary to a femoral cutaneous nerve injury which could have been traumatized. He diagnosed Claimant with a soft-tissue injury and testified he should have resolved within 3 months to a year. Dr. Rodriguez stated disc herniations are soft tissue injuries, and ninety percent of them get better on their own without requiring surgery. He further testified Claimant's condition should have stabilized within three to six months; he did not consider Claimant a surgical candidate in March, 2002. (EX-24, p. 4).

Dr. Rodriguez clarified the decreased sensation in Claimant's thighs was unrelated to his cervical and thoracic injuries. Overall, he could find no objective evidence to explain Claimant's subjective complaints of thoracic and cervical pain. Dr. Rodriguez further stated Claimant's neurological exam was normal, he had normal range of motion, compression maneuvers did not cause any pain and his muscular motor testing was normal. (EX-24, p. 4). Dr. Rodriguez noted Claimant was at maximum medical improvement as of March 22, 2002; he did not expect any further improvement or worsening within the following six to twelve months, as long as Claimant continued his exercises, which he recommended to improve Claimant's functioning and get him back to normal activities. Dr. Rodriguez felt Claimant stable to return to work, lifting no more than 50 pounds, which is an average restriction for patients similar to Claimant. Dr.

Rodriguez recommended narcotic medications, and opined Claimant did not need orthopedic care, neurosurgical care nor pain management, as he had never had a psychiatrist or psychologist. (EX-24, pp. 5, 20; EX-21, p. 3). On cross-examination, Dr. Rodriguez also testified Claimant did not currently need epidural steroid injections, as they are generally only beneficial for acute symptoms and not chronic pain. He reiterated his recommendation for a lot of physical therapy and exercise programs to improve Claimant's body posture and mechanics. (EX-24, p. 17).

Dr. Rodriguez followed-up with Claimant on March 29, 2005. Claimant presented with complaints of low back pain and coccyx with bilateral leg pain, in addition to pain in his neck and chest. Claimant described the pain as an eight out of ten, sometimes a ten of ten. Dr. Rodriguez testified pain at 10 out of 10 is quite severe, causing most people to be bedridden or at least have difficulty moving; however, he found no objective evidence to support such pain levels. At the deposition, he reviewed Claimant's 2004 MRI, but similarly could not find anything to substantiate or explain Claimant's current complaints of pain. (EX-24, pp. 6-7). Dr. Rodriguez did not ask Claimant what medications, if any, he was taking. X-rays taken at his office revealed degenerative changes at C5-6 and C6-7, but no instability or other lesions in the neck; he noted Claimant suffered chronic pain syndrome. (EX-24, p. 7).

Dr. Rodriguez also testified Claimant's return to work in 2002 was consistent with his recommendations; he had no explanation for why Claimant would have stopped work in 2004. At his 2005 evaluation of Claimant, Dr. Rodriguez noted there was no reason why Claimant could not return to work within restrictions of not lifting more than 50 pounds; however, he was concerned about severe depression or some other psychological condition Claimant may have been suffering which is why he did not offer a work status for Claimant. He approved and disapproved of Dr. Stokes' job findings based on Claimant's psychological condition at the time, as Claimant was physically capable of work. (EX-24, pp. 7-8, 10).

Dr. Rodriguez further stated his examinations also look for symptom magnification; he considers patients who magnify their symptoms to have a psychological problem and are not necessarily incredible or "faking it." Dr. Rodriguez testified he believed Claimant's subjective complaints of pain were related to severe depression and were not the result of secondary gain. However, he then stated he was unaware Claimant was in a lawsuit at the time of the evaluation, which is one of the trigger factors of secondary gain. He was also unaware Claimant had actually returned to work in 2001 for over two years; however, on cross-examination, he testified his 2005 report stated Claimant had returned to full duty work, and retracted his former testimony. (EX-24, pp. 8-9). Dr. Rodriguez testified he gave Claimant the benefit of the doubt; noting Claimant's exam and diagnostic studies did not correlate with his history and opining Claimant had some sort of depression. (EX-24, pp. 9-10). After becoming aware of Claimant's return to work, his current lawsuit and the medications he was taking, but

did not disclose, Dr. Rodriguez maintained Claimant required psychological treatment before being able to return to any work. (EX-24, pp. 10-11).

On cross-examination, Dr. Rodriguez clarified Claimant is capable of returning to work wherein he crawls, walking in little areas and lifts chains and hoists, etc., as long as he does not lift over 50 pounds. (EX-24, p. 16). He also testified if Claimant continues to have pain without objective justification, it would be advisable to figure out which of his work duties was causing the pain and modify his job description or provide him vocational re-training. He described placing a patient back to work as a subjective trial and error process. (EX-24, pp. 18-19).

G. Claimant's Personnel Records

Claimant's wage records for the year prior to his March 19, 2001, accident while working for Employer extend back to only August, 2000, when Employer acquired the company. The official records from Employer indicate Claimant received 34 paychecks totaling $33,665.92 between August 16, 2000 and March 28, 2001. Claimant's hours were generally lower from October, 2001, through May, 2002, but he put in full-time weeks with steady overtime until November, 2003, after which his pay records reflect lower hours, on the whole, until April, 2004. (EX-5). Claimant submitted a note stating he earned $33,414.00 at Employer between August 16, 2000 and March 19, 2001, and $21,477.00 at Employer's predecessor, Halter Marine, between March 20, 2000 and August 16, 2000, for total earnings of $54,981.00 in the 52 weeks prior to his injury. There are no wage records from Halter Marine submitted into evidence. (CX-24). Claimant's Social Security records for the year 2000 indicate he earned $31,704.83 at Halter Marine and $20,164.06 at Employer. (EX-2, p. 2).

Claimant's job description at Employer indicates he worked as foreman in a modified capacity starting in August, 2001; Claimant was to avoid bending, lifting, squatting, etc., as much as possible. The physical requirements of his job included standing and walking for 8 hours per day; frequent climbing, balancing, bending/stooping, kneeling, crouching, crawling, pushing/pulling, squatting and reaching above should level; lifting and carrying 100 pounds frequently; and working at heights. However, the form noted he had worked in a modified capacity within his physical limitations. On April 24, 2002, Dr. Bonnen reviewed these physical requirements and released Claimant to full-time work with lifting up to 50 pounds frequently and 25 pounds occasionally. Dr. Rodriguez issued the same opinion on April 26, 2002. (CX-22; CX-23).

Claimant's annual performance appraisal dated August 1, 2003, was on the whole average-exceptional, with poor marks for punctuality, reliability, organizational skills and time management. (CX-7). Following his leave of absence in April, 2004, Claimant was terminated on October 5, 2004, secondary to his six-month inactive status. His official

separation notice indicates his rehire status was "would not rehire" though is electronic termination form indicated rehire was not applicable. (CX-1; CX-2).

IV. DISCUSSION

A. Contentions of the Parties

Claimant contends he has reached MMI and is permanently disabled. He also contends he is totally disabled, as Dr. Bonnen released him to only medium duty work with lifting 50 pounds maximum, infrequently. Claimant also contends he cannot work at Employer because he is taking narcotic pain medication, and is also physically unable to continue working at Employer. Further, he argues lying down is the only way to relieve his pain. Thus, he should be entitled to total disability benefits as no employer would be able to accommodate his current condition. However, Claimant also argues Dr. Bonnen's testimony should not be credited as he worked closely with the claims examiner in the present case. Claimant argues he is entitled to Section 7 medical benefits for treatment of a doctor of his choice, specifically Dr. Yahtsu, as Dr. Bonnen refused to treat him. He is also requesting reimbursement for all expenses he has incurred out of his own pocket for treating with Dr. Madisetti. Finally, Claimant contends his indemnity benefits should be re-calculated based on an average weekly wage of $1,120.00 per week, based upon his earnings in the 52 weeks prior to his accident.

Employer contends Claimant is an incredible witness. They also assert he received appropriate treatment from his choice of physician, Dr. Bonnen, who they claim did not abandon Claimant but merely discharged him as Claimant was not in need of neurosurgery. Further, Claimant's treatments with Dr. Madisetti were not approved because his treating physician, Dr. Bonnen, referred Claimant to pain management specialist Dr. Garcia, who was the approved specialist by Employer. As such, Employer was not required to approve treatment by Dr. Madisetti. Similarly, because Dr. Bonnen testified he would continue to treat Claimant if he needed a neurosurgeon, Employer did not feel it needed to approve treatment by Dr. Yahtsu. Employer also contends Claimant can return to work as a fitter welder supervisor in the modified capacity he was performing satisfactorily before he quit, as there was no medical reason for his stopping work. In the alternative, Employer contends it has presented suitable alternative employment which would render Claimant entitled to permanent partial disability benefits. Finally, Employer contends Section 10(c) applies in lieu of 10(a) because Claimant was not working at Employer for the 52 weeks prior to his accident and injury.

B. Credibility

It is well-settled that in arriving at a decision in this matter the finder of fact is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and is not bound to accept the opinion or theory of any particular medical examiner. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467 (1968); *Louisiana Insurance Guaranty Ass's v. Bunol*, 211 F.3d 294, 297 (5th Cir. 2000); *Hall v. Consolidated Employment Systems, Inc.*, 139 F.3d 1025, 1032 (5th Cir. 1998); *Atlantic Marine, Inc., v. Bruce*, 551 F.2d 898, 900 (5th Cir. 1981); *Arnold v. Nabors Offshore Drilling, Inc.*, 35 BRBS 9, 14 (2001). Any credibility determination must be rational, in accordance with the law and supported by substantial evidence based on the record as a whole. *Banks*, 390 U.S. at 467; *Mijangos v. Avondale Shipyards, Inc.*, 948 F.2d 941, 945 (5th Cir. 1991); *Gilchrist v. Newport News Shipping and Dry Dock Co.*, 135 F.3d 915, 918 (4th Cir. 1998); *Huff v. Mike Fink Restaurant, Benson's Inc.*, 33 BRBS 179, 183 (1999).

Here, based on a record as a whole and my observation of Claimant's demeanor, I find Claimant is an incredible witness. Specifically, I note he contradicted himself a number of times at the formal hearing alone. He testified his finger surgery in 2002 was related to his 2001 accident, then stated it was not related to the accident; the medical records support Claimant's latter testimony. Claimant also testified he had no significant prior back problems and only took narcotic medications after his accident; however, he then conceded he suffered back spasms, pulled a muscle in his low back for which he took narcotic medications, and was hospitalized following a car accident all prior to his accident. Claimant testified his supervisor told him Employer did not have any light duty work for him after his accident, but required him to perform the heavy duty work he did before; he testified he could not modify his position. However, Claimant then testified his supervisor told him to perform modified duties and never threatened he would lose his job; Claimant clarified supervisors have the flexibility to delegate heavy duty work to their employees. The testimony of other fact witnesses corroborates the latter testimony.

Claimant also testified he did not have an alcohol problem, was never treated for alcoholism nor attended Alcoholics Anonymous. However, he then testified he is currently in AA, has had three DUI convictions and was diagnosed with Hepatitis C which his doctor told him was related to his chronic alcoholism. Likewise, Claimant failed to disclose his convictions for felony assault and deadly misconduct until pressed on cross-examination. He also testified he only had a ninth-grade education, but then stated he completed his GED and received a high school diploma. Finally, Claimant testified he could operate a forklift and cherry picker, if he was able to stand up and mover around as needed; then he testified he spends most of his days lying down secondary to pain.

In addition to his direct testimonial contradictions, Claimant also testified Dr. Garcia referred him to Dr. Yahtsu, and that Employer denied his request to treat with Dr. Garcia "a while back"; however, the medical records and Dr. Garcia's deposition do not support these statements. Aside from his hearing testimony, the medical records contain many instances where Claimant was not fully honest with his doctors. In particular, he failed to inform his physicians of the medications he was taking, and provided varying accounts of his return to work status.

The number of contradictions and inconsistencies contained in Claimant's hearing testimony belies the possibility that Claimant suffers from innocent lack of memory on specific, innocuous events which occurred far in the past. Rather, his testimony appears to have been calculated and intentional in its dishonesty with the focused result of benefiting his claim and not providing the undersigned with honest testimony. Some of these contradictions regarded his character, but others were directly related to his medical treatment and ability to work at Employer, central issues in the present claim. This is consistent with Claimant's varying stories with his physicians. Overall, I find the entirety of Claimant's testimony to be highly questionable and will only rely upon his statements that are supported and corroborated by the remainder of the record.

C. Nature and Extent of Claimant's Disability

Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Disability is an economic concept based upon a medical foundation distinguished by the nature (permanent or temporary) and the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Seidel v. General Dynamics Corp.*, 22 BRBS 403, 407 (1989); *Stevens v. Lockheed Shipbuilding Co.*, 22 BRBS 155, 157 (1989). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of maximum medical improvement (MMI).

The determination of when MMI is reached, so that a claimant's disability may be said to be permanent, is primarily a question of fact based on medical evidence. *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989); *Care v. Washington Metro. Area Transit Auth.*, 21 BRBS 248 (1988). An employee is considered permanently disabled if he has any residual disability after reaching MMI. *Lozada v. General Dynamics Corp.*, 903 F.2d 168, 23 BRBS (CRT)(2d Cir. 1990); *Sinclair v. United Food & Commercial Workers*, 13 BRBS 148 (1989); *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56 (1985). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition. *Leech v. Service Engineering*

Co., 15 BRBS 18 (1982), or if his condition has stabilized. *Lusby v. Washington Metro. Area Transit Auth.*, 13 BRBS 446 (1981).

In the present case, both parties contend Claimant has reached MMI and is permanently disabled. Dr. Rodriguez noted Claimant had reached MMI when he examined him on March 22, 2002. Dr. Bonnen's notes indicated Claimant had not reached MMI in August 2001; however, he issued a note on April 10, 2002, stating he agreed with Dr. Rodriguez's assessment. Pursuant to these records and absent any evidence to the contrary, I find Claimant reached MMI for his injuries sustained in his April, 2001, work accident as of March 22, 2002.

The Act does not provide standards to distinguish between classifications or degrees of disability. Case law has established that in order to establish a *prima facie* case of total disability under the Act, a claimant must establish that he can no longer perform his former Longshore job due to his job-related injury. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981); *P&M Crane Co. v. Hayes*, 930 F.2d 424, 429-30 (5th Cir. 1991); *SGS Control Serv. v. Director, OWCP*, 86 F.3d 438, 444 (5th Cir. 1996). He need not establish that he cannot return to *any* employment, only that he cannot return to his former employment. *Elliot v. C&P Telephone Co.*, 16 BRBS 89 (1984). If a claimant meets this burden, he is presumed to be totally disabled. *Walker v. Sun Shipbuilding & Dry Dock Co.*, 19 BRBS 171 (1986).

In the present case, Claimant's pre-accident position was that of a foreman at Employer's docks. Claimant testified his position was heavy duty, and the job description in CX-22 listed various duties including crawling, bending, kneeling, stooping and lifting up to 100 pounds on a frequent basis. Claimant's FCE conducted in July, 2001, limited his lifting to no more than 50 pounds occasionally and 25 pounds frequently. This was agreed upon by Dr. Bonnen, Dr. Garcia and Dr. Rodriguez who all opined Claimant was unable to fulfill the duties listed in CX-22. As a result, I find Claimant has proven he is unable to return to the job he was performing at the time of his injury, and thus has established a *prima facie* case of total disability.

C. Suitable Alternative Employment

Once the *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. *Turner*, 661 F.2d at 1038; *P&M Crane*, 930 F.2d at 430; *Clophus v. Amoco Prod. Co.*, 21 BRBS 261, 265 (1988). Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. *SGS Control Serv.*, 86 F.3d at 444; *Palombo v. Director, OWCP*, 937 F.2d 70, 73 (D.C. Cir. 1991); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). An employer may establish suitable alternative employment retroactively to the day when the claimant was able to return to work. *New*

Port News Shipbuilding & Dry Dock Co., 841 F.2d 540, 542-43 (4th Cir. 1988); *Bryant v. Carolina Shipping Co., Inc.*, 25 BRBS 294, 296 (1992). Where a claimant seeks benefits for total disability and suitable alternative employment has been established, the earnings established constitute the claimant's wage earning capacity. *See Berkstresser v. Washington Metro. Area Transit Auth.*, 16 BRBS 231, 233 (1984).

The Fifth Circuit has articulated the burden of the employer to show suitable alternative employment as follows:

> Job availability should incorporate the answer to two questions. (1) Considering claimant's age, background, etc.., what can the claimant physically and mentally do following his injury, that is, what types of jobs is he capable of performing or capable of being trained to do? (2) Within this category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which the claimant is able to compete and which he could realistically and likely secure? . . . This brings into play a complementary burden that the claimant must bear, that of establishing reasonable diligence in attempting to secure some type of alternative employment within the compass of employment opportunities shown by the employer to be reasonably attainable and available.

Turner, 661 F.2d at 1042-43 (footnotes omitted).

An employer may establish suitable alternative employment with a modified position in its own facilities. If the claimant is performing satisfactorily and for pay, then barring other signs of beneficence or extraordinary effort, the work precludes an award for total disability. *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 334 (1981).

In the present case, Dr. Bonnen and Dr. Garcia signed off on Claimant's job description outlined above and submitted as CX-22 in April 2002, with the caveat that the position be modified to include maximum lifting of 50 pounds occasionally and 25 pounds frequently, per the FCE. Indeed, Claimant returned to said modified duty in August, 2001.

Mr. Hooks, Mr. Steding and Mr. Garcia all testified foremen were able to delegate heavy work to their employees, and indeed some foremen were less hands-on than Claimant was before his injury. Claimant himself testified foremen could delegate their heavy work to the laborers, but that he voluntarily chose not to. Although Mr. Santiago Torres testified foremen did not have this flexibility, I find his testimony does not serve to outweigh that of the other witnesses, particularly in light of his close relationship to Claimant (the two are brothers) and the fact he has a prior conviction for a crime of dishonesty. Moreover, both Mr. Sparre and Mr. Knight confirmed that foremen could delegate heavy work to the laborers and thus modify their job to light duty. Mr. Knight

testified Employer issued a new policy in 2000 which required foremen to delegate all heavy physical activity to the laborers so as to avoid injuries. Mr. Sparre acknowledged all foremen perform some work on the barges, but it is not constant and he reiterated that Employer was willing to work to accommodate Claimant's physical limitations. There is no evidence in record to suggest Claimant's modified foreman position was sheltered employment to support a finding of total disability. Rather the credible evidence shows that Employer modified the foreman position to accommodate Claimant's complaints.

Moreover, I also find there is nothing in the record which establishes Claimant worked in extraordinary pain. Mr. Knight did testify Claimant started experiencing more problems after a few years, lost enthusiasm for his job and had slurred speech; in the week preceding his last day, Claimant appeared to be in bad pain and could not do his job. However, Mr. Knight also testified he encouraged Claimant to take it easy and stated Claimant performed his job well up until his last day. Both Mr. Sparre and Mr. Knight testified Claimant performed satisfactorily in a modified capacity until April 2004. Each of the witnesses testified they noticed Claimant had slowed down since his accident, but he was still able to perform the foreman duties. I note with particularity that Dr. Madisetti's records, with whom Claimant was treating in the spring of 2004, did not reflect an increase in Claimant's complaints of pain or worsening of his condition sufficient to validate his stopping work. All of Claimant's doctors opined he could work within the above lifting restrictions. Even if his pain had increased in April, 2004, the evidence indicates Employer was willing to accommodate his physical limitations. I accordingly find that Employer established suitable alternative employment by accommodating Claimant's physical limitations and allowing him to continue working as a supervisor in a modified capacity.

Claimant took a leave of absence from Employer on April 5, 2004. He had no medical excuse to keep him from work. As Claimant never returned to work, he was automatically terminated on October 5, 2004, after six months of absence. Claimant contends his removal from the workforce was the result of his work-related injury. I disagree. As stated above, Dr. Madisetti did not note any significant increase in Claimant's pain as last as March 17, 2004, which would impede his function. In May, 2004, Dr. Madisetti noted increased pain for which he prescribed Methadone, yet he did not note Claimant had a decrease in functioning. Dr. Madisetti testified Claimant's various medications kept him functioning such that he was able to continue working in April, 2004. This is supported by the opinions of Dr. Bonnen and Dr. Garcia.

Dr. Rodriguez recommended Claimant undergo a psychological evaluation as a prerequisite to his returning to work, although once cleared by a psychologist Claimant was released to work within the restrictions of lifting no more than 50 pounds infrequently, 25 pounds frequently. He also diagnosed Claimant with chronic pain syndrome. Notwithstanding these recommendations, the fact remains he was able to work in April, 2004, and did not possess a medical excuse restricting him from work in

any fashion. Significantly, Dr. Madisetti diagnosed Claimant with anxiety in 2003, but did not refer him to a psychiatrist or indicate it impeded his functioning. Dr. Rodriguez testified he wanted Claimant to be cleared to work by a psychologist or psychiatrist. If Claimant is currently unable to function secondary to his chronic pain and psychological condition, I find it is a result of his noncompliance with his medical treatment from Dr. Bonnen, the physical therapist and Dr. Garcia and working in excess of doctor prescribed physical limitation and against instructions from supervision. More importantly, it was not manifest in 2004 when Claimant abruptly stopped working. That is not to say that Claimant did not and does not continue to have work related pain for which he is entitled to medical treatment.

In light of the foregoing, I find Claimant was capable of working at Employer at a modified capacity. I do not credit Claimant's assertion that he lost work or had to quit his job due to work related pain. Employer provided suitable alternative employment and is not liable for additional compensation. In the alternative, Employer produced evidence of other suitable employment through the testimony of Mr. Stoke showing the availability of light duty work as a cashier and pizza maker. Per Dr. Stokes' report, these positions would render an weekly wage of $259.60 - $280.00 per week, or an average of $270.00 per week.

D. Medical Benefits

Section 7(a) of the Act provides that "the employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). However, under § 7(d)(1), an employee is not entitled to reimbursement for medical treatment or services unless:

> (A) his employer refused or neglected to provide them and the employee has complied with subsections (b) and (c) and the applicable regulations, or
>
> (B) the nature of the injury required the treatment and services and, although his employer . . . knew of the injury, [it] neglected to provide or authorize them.

When an employer learns of its employee's injury, it must authorize medical treatment from the employee's own choice of physician. 33 U.S.C. §§ 907(b), (c)(2). In determining whether a doctor is the employer's physician, and not the claimant's choice, "the relationship between the doctor and the employer must be such that it is reasonable to assume that the employer will adopt or has adopted the doctor's medical conclusions." *Slattery Assoc., Inc. v. Lloyd and Director, OWCP*, 725 F.2d 780, 785 (D.C. Cir. 1984).

When a claimant chooses his initial physician and then wishes to change treating physicians, he must first request consent for a change. Consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. 33 U.S.C. § 907(c)(2); 20 C.F.R. § 702.406(a); *Roger's Terminal v. Office of Worker's Compensation,* 784 F.2d 687,693 (5th Cir, 1986);*Armfield v. Shell Offshore, Inc.*, 25 BRBS 303, 309 (1992)(Smith, J., dissenting on other grounds); *Senegal v. Strachan Shipping Co.*, 21 BRBS 8, 11 (1988). Otherwise, an employee may not change physicians after his initial choice unless the employer, carrier, or deputy commissioner has given prior consent upon a showing of good cause for change; however, the employer has no obligation to approve a change, even upon a showing of good cause. 33 U.S.C. 907(c)(2).

In the present case, Employer authorized treatment by Dr. Mileski at UTMB, neurosurgeons Dr. Bonnen and Dr. Pazkaban, pain management specialist Dr. Garcia and orthopedic surgeon (consultant) Dr. Rodriguez. Specifically, Claimant officially requested Dr. Mileski and Dr. Bonnen as his choice of physician and neurosurgeon, respectively.

In November, 2001, Claimant requested authorization to be treated by Dr. Frank Yahtsu, a professor of neurology, for pain management. When Employer refused that request Claimant sought treatment from pain management specialist, Dr. Madisetti. Claimant did not seek additional authorization for this treatment nor did he provide medical bills from Dr. Madisetti to Employer on a timely basis. Rather Claimant paid Dr. Madisetti out of his own funds the sum of $2,965.00. (CX-42)

In the present case neither Dr. Bonnen nor Dr. Garcia refused to treat Claimant. However, Claimant had the right to choose a pain management specialist since Dr. Bonnen admitted he was not willing or competent to administer such necessary treatment.[6] Although Claimant saw Dr. Garcia one time on a referral from Dr. Bonnen, Claimant elected as he had a right to do under 20 C.F.R. Section 702.406 (a), the necessary and appropriate services of Dr. Yatsu and then Dr. Madisetti. Once the employer has refused to provide treatment or to satisfy a claimant's request for treatment, the claimant need only establish that the unauthorized medical services were necessary and reasonable for his work injury in order to be compensable. *Wheeler v. Interocean Stevedoring*, 21 BRBS 33 (1988); *Rieche v. Tracor Marine*, 16 BRBS 272, 275 (1984);

[6] A claimant establishes a *prima facie* case when a qualified physician indicates that treatment is necessary for a work-related condition. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989); *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294, 296 (1988).

Beynum v. Washington Metro. Area Transit Auth., 14 BRBS 956, 958 (1982); *Shahady,* 13 BRBS at 1009; 33 U.S.C. § 7(d). Although neither Claimant nor Dr. Madisetti did not apparently timely file such reports with Employer within 10 days of service, I find such failure excusable by Employer's refusal to authorize such services. *Slattery Associates v. Lloyd,* 725 F.2d 780 (D.C. Cir. 1984). Indeed there is no apparent prejudice to Employer who was certainly aware of the injury and need for pain management. *Rogers Terminal,* 784 F.2d at 693-94.

E. Attorney Fees

No award of attorney's fees for services to the Claimant is made herein since a proper application for fees has not been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision to submit an application for attorney's fees. A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

1. Employer shall reimburse Claimant for medical expenses of $2,965.00 incurred as a result of his medical pain management treatment by Dr. Madisetti and shall authorize future and reasonable, medical pain management by Dr. Yatsu or Dr. Madisetti, for pain associated with his work-related injuries pursuant to Section 7(a) of the Act.

2. Claimant's counsel shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges, serving a copy thereof on Claimant and opposing counsel who shall have twenty (20) days to file any objection thereto.

A

CLEMENT J. KENNINGTON
ADMINISTRATIVE LAW JUDGE